The Christ Hospital
ORTHOPAEDIC ASSOCIATES

Registration Form
(Please Print Legibly)

Freiberg Orthopaedics & Sports Medicine

Patient Information:

Name: ____ Preferred Nickname: ____________
Last First MI

Date of Birth: __________ Sex: M F Marital Status: S M D W

Maiden Name: ________________ SSN: ____________________

Address: ____
Street City State Zip

Home Phone ( ) __________ Work Phone ( ) __________ Cell Phone ( ) ____________

Primary Care Physician: ____________________ Referring Physician: ________________________

Who referred you/ how did you find our practice? Please check one:

___MD referral ___Chiropractor ___Physical Therapist ___BWC ___Family ___Friend ___Insurance Co

___Internet ___E.R. ( ) ___I am an established patient

Emergency Contact:

Name: ____ Relationship to Patient: ________________
Last First MI

Address: ____
Street City State Zip

Home Phone ( ) __________ Work Phone ( ) ____________ Cell Phone ( ) ____________

Legal Guardian: Y N POA: Y N

Employment Information:

______________________ _______________ _________________ _________________
Employer Work Status Occupation Phone

Is this a work related injury: ☐ Yes ☐ No If yes, claim # _______________

Responsible Party:

Name: _________________________________ Relationship to Patient: _____________________
Last First MI

Address: ____
Street City State Zip

Home Phone ( ) ____________ Work Phone ( ) ____________ Cell Phone ( ) ____________

Insurance Information:

Primary Insurance Name: ______________________________ Group #: ______________________

Policy Id #: _________________________ Subscriber Name: ______________________________

Subscriber DOB: ___________ Subscriber Employment Info: ________________________________

Subscriber SSN: ___________________

Secondary Insurance Name: __________________________ Group #: ________________________

Policy Id #: ______________ Subscriber Name: ____________________ Subscriber SSN: _________

Subscriber DOB: ___________ Subscriber Employment Info: _________________________________

Patient Name: **Date of Birth:**

Please circle and answer to each question:

May we release your test results to your:
Spouse? Yes No Name: ___________________
Parent? Yes No Name: ___________________
Other? Yes No Name: ___________________ (Relationship: _________________________)

May we discuss billing questions with your:
Spouse? Yes No Name: ___________________
Parent? Yes No Name: ___________________
Other? Yes No Name: ___________________ (Relationship: _________________________)

May we leave a message concerning results on your answering machine?
Yes No

May we call you at your place of employment?
Yes No

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)
We are legally required to provide you with a copy of our NOTICE OF PRIVACY PRACTICES the first time you receive care at TCHOA. If you are here for medical treatment, you will be given a copy as soon as possible. **PATIENT OR PATIENT'S LEGAL REPRESENTATIVE: CHECK AND SIGN BELOW.**

_______________ I have received a copy of the Notice of Privacy Practices

_______________ I previously received a copy of the Notice of Privacy Practices

_______________ I do not want a copy of the Notice of Privacy Practices

AUTHORIZATION

By signing below, I state the above information to be true and correct. I hereby authorize the physicians of TCHOA to treat the patient named in this document for medical and surgical procedures on scheduled or emergency basis, at any location and to submit a claim to my insurance carrier(s) or it intermediaries, to issue payment DIRECTLY to TCHOA on behalf of such rendered services. **I understand that I am financially responsible to this office for any balance not covered by my insurance carrier.** A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

____ _________________________________

Signature (Patient should sign here, if 18 years or older. If under 18, guarantor should sign.) DATE